

Preliminary Recommendations

Hospitals send results

Recommendation

The IE WG disagrees with the CMS NPRM decision to exclude this objective and recommends that CMS restore the HITPC-recommended requirement for hospitals be capable of sending structured labs using LOINC result codes and HL7 2.5.1. However existing interfaces should not be required to be replaced as long as the results are structured data.

Background

- This was recommendation that originated in IE WG, was approved by HITPC, and then rejected by CMS NPRM.

Discussion

- Hospital labs are an important supplier of lab results to ambulatory providers, representing approximately 40 percent of the ambulatory lab testing market. MU is a powerful and unique lever for getting standardization in an area that has historically been fragmented and difficult to align yet is critically important for the achievement of a wide variety of MU objectives and goals.
- Would constrain some of the optionality that exists in the market today, which is hindering hospital lab results delivery to ambulatory EHRs as each vendor tends to impose different interface requirements.
- Many hospitals would find this objective beneficial because it would create a uniform standard for laboratory exchange transactions--using the LOINC subset and lab results interface requirements developed by the S & I initiative--which would eliminate variation in interfaces, reducing cost and time to deploy.
- Would directly enhance the ability of EPs to meet meaningful use requirements including incorporating laboratory test results into their ambulatory EHRs as structured data, generating lists of patients with particular conditions, and using decision support.
- Would enhance EPs' CQM capabilities by increasing the amount of structured data available for measurement, and by enhancing the quality and integrity of that data, which is critical not only to MU but also to accountable care.
- While it is appropriate to require a hospital laboratory systems to be capable of providing LOINC-coded results via HL7 2.5.1, requiring conversion of all of their existing structured data lab interfaces to be converted to 2.5.1 and LOINC by 2014 would cause chaos around the nation.

Perform an HIE Test

Recommendation

The IE workgroup agrees with the CMS proposal to remove this objective for Stage 1 with no replacement.

Background

- The IE WG agreed to this recommendation in an earlier call.
- HITPC comment requested that we consider NPRM “Option 4” – replace the Stage 1 objective with one case of actual electronic transmission of a summary of care document for a real patient either to another provider of care at a transition or referral or to a patient authorized entity

Discussion

- According to CMS statistics, this objective has not been widely chosen by EPs or EHs to date. One contributing factor is likely confusion about the intent and requirements of the objective. This was a comment the workgroup made in its Stage 1 recommendations.
- It is prudent to remove the objective because it is not well enough defined to be made a Core objective, and few EPs and EHs are choosing it as a Menu objective.
- We do not recommend replacing this objective because relatively few providers will be affected by it as the Stage 1 cohort diminishes over time, the intent of the objective is achieved by Stage 2 interoperability requirements, and we want to minimize the number of changes made to Stage 1 requirements to reduce market confusion.
- Replacing this objective with Option 4 would not be productive because single tests of capabilities end up being little more than “check the box” objectives that do not tend to have a strong or lasting behavioral impact.

Transition of care summaries

Recommendation 1

Raise the exclusion threshold for the 65% measure requirement from 0 to [a larger number]

Background

- In previous IE WG call, concern was expressed that excluding cases where health information access is provided through the EHR could make it challenging to meet the 65% threshold for the remaining transfers of care. The NPRM is clear that the 65% threshold is not an electronic requirement and thus can be met by providing care summaries to patients as paper copies or on other portable media such as CDs, USB-drive, etc.

Discussion

- NPRM allows exclusions only for providers that have 0 transitions. This could present a problem for providers with a non-zero but nevertheless small number of transitions. For example, may be difficult to achieve 65% requirement if a provider had only 5 qualifying transitions.

- [Need to include discussion of what threshold we would recommend.]

Recommendation 2

The IE WG supports the requirement to conduct electronic transmission of care summaries, but recommends removing the cross-vendor requirement to meet the 10% electronic exchange threshold. The IE WG also recommends not including in the denominator referrals to providers that have access to view or query patient clinical data, either directly from the referring provider's EHR or from a repository or HIE populated with patient data by the referring provider. There needs to be an exclusion if the resultant denominator is less than [XXXX] referrals per year.

Background

- IE WG agreed to this recommendation on an earlier call.
- HITPC comments expressed concern that vendors may not truly develop standards-based exchange capabilities unless required to exchange with other vendor systems
- IE WG also discussed whether to allow query-based transactions for fulfillment of this objective. For example, if a specialist queries a PCP practice for information, should that count as a transfer of care summary for the PCP practice? Pros: Rewards those who have deployed more sophisticated query/retrieve capabilities. Cons: If it's the PCP practice that gets credit for the exchange, how would this be measured? Systems would have to be able to measure volume of solicited summaries of care sent in response to a query supporting a transition of care. Also, this seems to absolve the PCP from the requirement to proactively send the care summary in the first place, which dilutes the intent of the objective.

Discussion

- The workgroup supports the requirement to conduct electronic transitions with non-affiliated organizations, but not with the requirement regarding use of a different vendor.
- There are many markets, both rural and urban, where a single vendor dominates the health care delivery system and where this requirement would correspondingly very difficult to achieve.
- The goal of the objective should be to increase standards-based electronic transmission of summaries according to patient flow, regardless of which vendors the provider organizations use. The certification and electronic measurement processes should be made robust enough to ensure that required standards are utilized regardless of which system the recipient provider is using.
- It would be very challenging to develop an automated measurement procedure that could distinguish which vendor system the receiving provider is using
- An unintended consequence of only recognizing cross-vendor exchange is that it undercuts the incentive for vendors to deeply integrate national standards into their applications. Rather than building their products around national standards, they might instead retain and deeply integrate their own favored proprietary modes for exchange within their system and maintain less integrated workflows for standards-based exchange outside of their system.

- For IE WG consideration: Should query-based exchange count toward this objective? For example, if a specialist queries a PCP practice for information, should that count as a transfer of care summary? Pros: Rewards those who have deployed more sophisticated query/retrieve capabilities. Cons: If it's the PCP practice who gets credit for the exchange, how would this be measured?
- How should we count subscription-based models where the summaries are automatically pushed to the consultant?

Medication reconciliation

Recommendation

The IE WG agrees with the medication reconciliation objective and measures, but recommends that the exclusion criteria account for specialties and/or clinical situations where medication reconciliation would not be warranted or necessary.

Discussion

- Some situations do not require medication reconciliation and the requirement could impose workflow burdens with no corresponding clinical benefit (for example, orthopedist treating sprained wrist of an elderly person who is on multiple medications – med rec could be time-consuming but may not be relevant to the diagnosis or treatment)
- This expansion of allowed exclusions is especially important because this requirement is being moved from Menu to Core

Electronic prescribing

Recommendation/Comment #1

The IE WG agrees with increasing the eRX requirement but notes that the 65% threshold may still be difficult to achieve for some providers given the wide variation in eRX infrastructure across the country and the relatively low non-universal use of eRX among mail-order pharmacies. The IE WG also feels that prescriptions to internal pharmacies should be excluded from the denominator

Discussion

- IE WG remains concerned about the difficulty of achieving this objective in many parts of the country
- eRX adoption is increasing rapidly, however, and setting a relatively high threshold of 65% may spur more rapid improvements in eRX infrastructure
- Need info on eRX use among mail-order pharmacies
- Need to exclude prescriptions to internal pharmacies from the denominator

Recommendation #2

The IE WG supports the requirement to check formularies but recommends that:

- The formulary requirement be separated from the eRX requirement so that formulary-checking for ANY prescription be counted toward the objective
- Providers be required to conduct formulary checks only in cases when a patient-relevant formulary is-could reasonably have been available to the provider
- Providers manually attest to the reasonable availability of a formulary specific to ~~the-patient~~s for each ~~prescribing-event~~payor/plan
- Measures focus on the percent of formulary checks conducted when patient-relevant formularies were-could reasonably have been available
- Consider using a lower threshold (e.g. 50%) if eRx, faxed, and printed prescriptions are being included in the denominator.

Background

- IE WG in earlier call discussed concerns about formulary checking requirement
- See attached analysis from Dr Larry Garber

Discussion

- Formularies are specific to the health insurer and health insurance product of each individual patient
- Relevant formularies are thus not often available to the provider, either because the health plan does not participate in national eRX network or the health plan has not made an electronic formulary version readily available for a particular EHR
- eRX is not tied to formulary availability in the market, because not all health plans make formularies available through national eRX networks, and conversely, because formularies may be available for prescriptions that are not electronically transacted due to patient preference, low pharmacy adoption, etc.

Public health (general)

Recommendation/comment

The IE WG concurs with the NPRM inducement for improved information for public health, and in particular, with requiring public health submissions “except where prohibited” in Stage 1.

IE WG recommends more specific definitions for the key parameters of the public health requirements in order to create an infrastructure to realize better public health information.

- Specifically define “successful ongoing submission” to be 10% of all qualifying transactions increasing 10 percentage points per year over Stage 2 to a maximum of XX%

- Specify transport requirements for public health transactions, aligned with transport requirements specified for electronic transition of care summaries. Grandfather existing transport approaches and apply new transport requirements only on new or replacement interfaces.

Background

- IE WG discussed on earlier call

Recommendations

- Recognize that public health is very decentralized, and that MU did not provide funding or authority over CDC or public health departments
- Nevertheless, allowing so much discretion to state public health departments will be a significant barrier to success
- Combined with “except where prohibited” requirement, imposes unreasonable burden on vendors to meet multiple, highly varied, state-specific requirements on use and transport standards

Public health (Syndromic surveillance)

Recommendation

The IE WG supports CMS’ proposal to make Syndromic Surveillance a Core requirement for EH/CAHs and a Menu requirement for EPs.

Background

- This was the original recommendation from the IE WG last year

Discussion

- Public health infrastructure is not yet prepared to receive syndromic surveillance data from ambulatory care settings.
- The necessary standards are under development but do not yet exist so the WG is unable to assess the reasonableness of the requirement.
- We also note that for EPs this would be a new public health requirement that did not even exist in the paper world, so will be a whole new workflow and adoption challenge for ambulatory practices

Public health (immunizations)

Recommendation

IE WG recommends that CMS broaden exclusion criteria that would otherwise require provider submission where immunization registry has designated a “health information exchange” or other method/organization to ensure that such alternative is a reasonable alternative in terms of price and integration requirements

IE WG recommends that CMS define more specifically which immunizations are required to be reported by providers, and only include in the denominator those that were administered by the provider (as opposed to recording historical administrations).

Background

- This was the original recommendation from the IE WG last year

Discussion

- NPRM allows exclusion where a public health entity is not capable of receiving immunization information, but exclusion does not apply where public health entity has designated a “health information exchange” or other entity to receive such information on its behalf
- To the extent that such organizations may charge a fee or have high integration or other requirements, the exclusion should specify that the requirements for submission through the designated entity should be “reasonable”

Public health (cancer and specialty registries)

Recommendation

IE WG recommends that CMS specifically designate which registries in each state or territory would qualify for this objective. These registries should also adhere to any standards being required through EHR certification.

Discussion

- The NPRM refers to “State” cancer registries and specialty registries but does not define what these are
- Many registries may charge fees or impose integration requirements that present an unreasonable burden on provider and EHR technology vendors
- It’s unclear which types of cancers should be reported, and whether it’s cost-effective to the healthcare system to have multiple members of the care team (PCP, Oncologist, surgical specialist, radiation oncologist) all reporting to the registry on the same patient.

View, download, transmit

Recommendation

IE WG supports the intent of the patient engagement objectives but recommends the following changes:

- Objective should be Menu set rather than Core because it is a new requirement based on patient actions
- Measure should be changed from view/download/transmit to “~~Registration~~Registered Users” for a patient portal or method to transmit to a patient-controlled application (eg, PHR)
- Threshold should gradually increase over the Stage 2 period, beginning at 10% in year 1 and increasing 5 percentage points per year to a maximum of 30%

Background

- IE WG discussed this on last call

Discussion

- This is one of only two objectives (secure messaging is the other) that would link provider success to specific patient actions – this is a sufficiently new dimension on MU requirements that it should be Menu rather than Core
- There is wide variation in market success with patient adoption of patient-facing applications; the vast majority of EPs and EOs do not even have such technology in place, and of those who do, some larger, more experienced organizations have reached relatively high (50%+) active patient usage, but most providers have likely not been able to get adoption at such high levels
- Agree that providers play an important role in patient adoption and thus agree with the intent of the objective to motivate EPs and EOs to take actions that encourage the use of such technologies. Our primary concern with the NPRM on this issue is that it goes too far given the state of the industry. It expects providers to motivate relatively sophisticated use of nascent technologies by a significant fraction of patients, when the reality is that providers have real but limited influence to affect patient adoption, especially as these nascent technologies are very new both to providers and to patients.
- “View/download/transmit” requires that a patient not only create a patient access account, but that they use it an ongoing manner. IE WG believes that providers currently have (or will have) the ability to affect one-time account creations, but not on-going use.
- IE WG thus proposes to incent and measure providers’ ability to get patients to “register” for such technologies, where “register” would mean the one-time step of having patients sign-up for an account, have security credentials (username/password) issued, and initiate or activate the account (perhaps by an initiation log-on to the account or responding to an activation email).

- In order to encourage forward progress during Stage 2, also recommend that the performance threshold be gradually increased over the Stage 2 time period to motivate providers to continue to sign-up new patients. Begin with 10% in first year, but increase 5 percentage points per year to a maximum of 30%. This could be increased during consideration of the Stage 3 NPRM if market uptake at that time would appear to allow it.

Secure messaging

Recommendation

IE WG agrees with the intent to encourage greater electronic communication between patients and providers, however, we recommend modifying this measure to also count physician-initiated messages that are specifically relevant to the patient's clinical situation.

- Objective should be Menu set rather than Core because it is a new requirement based on patient actions
- Measure should count physician-initiated messages as well as patient-initiated, and as such, the threshold increased from 10% to ~~XX~~20% of patients registered to use the secure messaging system

Background

- IE WG considered this objective on our last call

Recommendation

- This is one of only two objectives (view/download/transmit is the other) that would link provider success to specific patient actions – this is a sufficiently new dimension on MU requirements that it should be Menu rather than Core
- There is wide variation in market success with patient adoption of patient-facing applications; the vast majority of EPs and EOs do not even have such technology in place, and of those who do, some larger, more experienced organizations have reached relatively high (50%+) active patient usage, but most providers have likely not been able to get adoption at such high levels
- Agree that providers play an important role in patient adoption and thus agree with the intent of the objective to motivate EPs and EOs to take actions that encourage the use of such technologies. Our primary concern with the NPRM on this issue is that it goes too far given the state of the industry. It expects providers to motivate relatively sophisticated use of nascent technologies by a significant fraction of patients, when the reality is that providers have real but limited influence to affect patient adoption, especially as these nascent technologies are very new both to providers and to patients.
- A further barrier is that most health insurers do not currently pay for electronic communications with patients. While the limited evidence from market experience suggests that such communications do not, on net, generate more workload for providers once fully in place, uncertainty about this point and the upfront investment in time and effort required to put it in

place make the lack of compensation for the model a significant barrier to widespread acceptance by providers

- NPRM proposes a level of use (10%) that, combined with the view/download/transmit objective, would suggest that providers would have to encourage 100% of patients who meet the view/download/transmit objective to meet this objective as well. It makes more sense to make the denominator the number of patients who have registered to use secure messaging.
- Anecdotal evidence from the field suggests that the biggest motivator of patient use of secure messaging is provider use of such messaging
- Recommend including in the numerator provider- and patient-initiated messages. By including measures that providers directly control, we would also recommend raising the threshold from 10% to ~~XX~~20% of patients registered to use the secure messaging system.